(6) Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in section (E)(5) above.

(7) State funds only payment amounts (E)(3) are then added to the results of (E)(6) to determine the total distribution amount for each rural hospital.

TDAERH = (TDAERH + SFOER)

F. Determination of Disproportionate Share Payments for Specialty Hospitals

1. The following formula shall be used by the agency to calculate the total amount available for hospitals that participate in the specialty hospital disproportionate share program:

TAE=(MD/TMD) x TA

Where:

TAE=total amount earned by a specialty hospital.

TA=total appropriation for payments to hospitals that qualify under this program. (as found in Appendix B)

MD=total Medicaid days for each qualifying hospital.

TMD=total Medicaid days for all hospitals that qualify under this program.

2. In order to receive payments under this section, a hospital must be licensed

in accordance with part I of chapter 395, participate in the Florida Title XIX program, and meet the following requirements:

a. Be certified or certifiable to be a provider of Title XVIII services.

b. Receive all of its inpatient clients through referrals or admissions from county public health departments, as defined in chapter 154.

c. Require a diagnosis for the control of a communicable disease for all admissions for inpatient treatment.

G. Determination of Primary Care Disproportionate Share Payments

1. Disproportionate Share Hospitals that qualify under VI.A. above for regular disproportionate share hospital payments and meet all of the following requirements shall qualify for payments under the primary care disproportionate share program. For state fiscal year 2002-2003 only, hospitals that qualified and received a payment under this Section in state fiscal year will qualify to receive a payment in state fiscal year 2002-2003.

a. Agree to cooperate with a Medicaid prepaid health plan, if one exists in the community.

b. Agree to ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.

c. Agree to coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level, except that eligibility may be limited to persons who reside within a more limited area, as agreed

to by the agency and the hospital.

d. Agree to contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility, primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours.

e. Agree to cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.

f. Agree to, in cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care program to persons who are not eligible for the Medicaid program, and who reside within the area.

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g. Agree to provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do not have private health insurance, regardless of ability to pay, on the basis of available space, except that nothing shall prevent the hospital from establishing bill collection programs based on ability to pay.

h. Agree to work with the Florida Healthy Kids Corporation, and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan.

i. Agree to work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate use of health services.

j. Agree to work with the local health council to develop a plan for promoting access to affordable health care services for all persons who reside within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health insurance generally.

2. Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may not receive payments under this section until compliance is achieved.

3. Hospitals that wish to participate in the primary care disproportionate share program must certify to the agency that they meet the requirements of 1. a.-j. above prior to any qualifying hospital receiving payment under this program.

4. For state fiscal year 2002-2003 only, payments to hospitals that qualify under this Section shall be in the same proportion as payments made in state fiscal year 2001-2002. Total payments for Primary Care DSH shall be limited to total amount appropriated in Appendix B.

5. The following formula shall be used to calculate a hospital's disproportionate share factor:

$$DSF = \frac{UIL \times CCD}{TCCD}$$

Where:

DSF=the disproportionate share factor.

UIL=the number of uninsured lives in the qualifying hospital's county.

CCD=audited charity care days per hospital.

TCCD=total audited charity care days for the county.

Note:

a. The number of uninsured lives are based on the uninsured lives per county for 1994 as determined from the 1993 RAND study.

b. The audited charity care days are based on the 1994 charity data used to calculate payments under the regular disproportionate share program.

6. The following formula shall be used to calculate a hospital's charity care not covered:

$$CCNC = 1 - \frac{RDSHP}{NCC}$$

Where:

CCNC=charity care not covered.

RDSHP=the current regular DSH payment for the qualifying hospital.

NCC=the amount of charity care used for calculating charity care days in the Rural Disproportionate Share Program.

7. The following formula shall be used to calculate the adjusted disproportionate share factor:

$$ADSF = [DSF \times (1+CCNC)],$$
If CCNC<1, then ADSF=DSF

Where:

ADSF=adjusted disproportionate share factor for the qualifying hospital.

7. The following formula shall be used to calculate the total amount earned for each hospital:

$$TAE = TA \times \frac{ADSF}{SASDF}$$

Where:

TAE=total amount earned.

TA=total appropriation. (as found in Appendix B)

ADSF=adjusted disproportionate share factor.

SASDF=sum of the ADSF for all qualifying hospitals.

H.Disproportionate Share Program for Children's Hospitals

1. For state fiscal year 2002-2003 only, no disproportionate share payments shall be made to the children's disproportionate share hospital program. The Agency for Health Care Administration shall use the following formula to calculate the total amount earned for hospitals that participate in the children's hospital disproportionate share program:

$$TAE = DSR \times BMPD \times MD$$

Where:

TAE = total amount earned by a children's hospital

DSR = disproportionate share rate

BMPD = base Medicaid per diem

MD = Medicaid Days

2. The agency shall calculate the total additional payment for hospitals that participate in the children's hospital disproportionate share program as follows:

$$TAP = \frac{(TAE \times TA)}{STAE}$$

Where:

TAP = total additional payment for a children's hospital.

TAE = total amount earned by a children's hospital

TA = total appropriation for the children's hospital disproportionate share program. (as found in Appendix B)

STAE = sum of total amount earned by each hospital that participates in the children's hospital disproportionate share program.

3. A hospital may not receive any payments under this section until it achieves full compliance with the applicable rules of the agency. A hospital that is not in compliance for two or more consecutive quarters may not receive its share of the funds. Any forfeited funds must be distributed to the remaining participating children's hospitals that are in compliance.

VII. Special Medicaid Payment (SMP) Reimbursement Methods

A.Special Medicaid Payments

1. Effective July 1, 2002, Special Medicaid Payments will be made on a quarterly basis to statutory teaching hospitals, family practice teaching hospitals as defined in s. 395.805, Florida Statutes, hospitals providing primary care to low-income individuals, hospitals that operate designated or provisional trauma centers and rural hospitals. Statutory teaching hospitals that qualify for the Graduate Medical Education disproportionate share hospital program (DSH) shall be paid $13,559,912 distributed in the same proportion as the Graduate Medical Education DSH payments. Effective January 1, 2003, hospitals that qualify for the GME DSH program will receive an additional $3,920, 792. Family practice teaching hospitals, except for those that are public hospitals, shall be paid $1,812, 908 to be distributed equally between the hospitals. Effective January 1, 2003, family practice teaching hospitals, except those that are

public hospitals, shall be paid an additional $585, 864. Hospitals providing primary care to low-income individuals and participating in the Primary Care DSH program shall be paid $13,559,912 distributed in the same proportion as the Primary Care DSH payments. Effective January 1, 2003, hospitals in the Primary Care DSH program will receive an additional $4,506,657. Hospitals that are designated or provisional trauma centers shall be paid $12,900,000. Of this amount $5,100,000 shall be distributed equally between the hospitals that are a Level I trauma center; $5,000,000 shall be distributed equally between the hospitals that are either a Level II or Pediatric trauma center; $2,800,000 shall be distributed equally between the hospitals that are both a Level II and Pediatric trauma center. Effective January 1, 2003, hospitals that are designated or provisional trauma centers shall be paid an additional $5,500,000. Of this amount, an additional $2,068,800 shall be distributed equally between the hospitals that are Level 1 trauma center; $2,168,800 shall be distributed equally between the hospitals that are either a Level II or Pediatric trauma center; $1,262,400 shall be distributed equally between the hospitals that are both Level II and Pediatric trauma center. Rural hospitals participating in the Rural Hospital DSH program shall be paid $9,315,000 distributed in the same proportion as the rural DSH payments. Effective January 1, 2003, rural hospitals participating in the Rural Hospital DSH program will receive an additional $2,185,000.00

2. Effective July 1, 2002, as prescribed by the General Appropriations Act for the current state fiscal year, Special Medicaid Payments will be made

on a quarterly basis to hospitals that serve as a safety net in providing emergency and inpatient care to low-income and indigent individuals. Total payments will be made in the following manner: $50,828,951 shall be paid to University Medical Center - Shands; $13,703,527 shall be paid to Tampa General Hospital; $7,971,838 shall be paid to Mt. Sinai Medical Center; $6,604,745 shall be paid to All Children's Hospital; $5,750,230 shall be paid to Miami Children's Hospital; $3,641,219 shall be paid to Orlando Regional Medical Center; $2,396,945 shall be paid to Shands Teaching Hospital; $2,562,400 shall be paid to Jackson Memorial Hospital; $500,000 shall be paid to Lee Memorial Hospital/CMS; $500,000 shall be paid to Baptist Hospital of Pensacola; $55,072 shall be paid to Florida Hospital; $54,402 shall be paid to Tallahassee Memorial Hospital; $52,835 shall be paid to St. Joseph's Hospital and $51,222 shall be paid to St. Mary's Hospital.

3. Hospitals whose charity care and Medicaid days as a percentage of total hospital days equal or exceed fourteen and one-half percent, and are a trauma center, shall be paid $2,000,000 if their variable cost rate is less than their variable cost target or county ceiling target. Payments under this provision will be made quarterly. The Agency shall use the 1997 audited DSH data available as of March 1, 2001.

4. Effective July 1, 2002, Special Medicaid Payments will be made on a quarterly basis to statutory teaching hospitals to enhance medical education programs. Total payments will me made in the following manner: $11,702,078 shall be paid to Orlando Regional Medical Center;

$1,204,557 shall be paid to University Medical Center-Shands; $1,977,376 shall be paid to Tampa General Hospital.

5. Effective July 1, 2002, Special Medicaid Payments up to $7,251,632 will be made on a quarterly basis to hospitals to enhance primary care services to underserved areas of the state. AHCA shall work in collaboration with the Florida Department of Health to determine which hospitals will receive these payments.

6. Special Medicaid Payments totaling up to $232,693,505 will be made on a quarterly basis to hospitals providing enhanced services to low-income individuals through agreements with local county or other governmental entities. Effective January 1, 2003, the total of the Special Medicaid Payments will increase in the amount of $41,430,759.The amount of the Special Medicaid Payment to each hospital is proportional to the amount of the intergovernmental transfer received from the local county or governmental entity.

7. Payments under sections 1 through 5 above are for services provided on or after July 1, 2002.

B. Medicaid Upper Payment Limit (UPL)

The Special Medicaid Payments listed in section A above are being made in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each class of hospitals (non-State government-owned or operated facilities and privately owned and operated facilities), the amount that would have been paid under Medicare payment principles for the previous year will be calculated and compared to what payments were

actually made by Medicaid during that same time period. The calculation may then be used to make payments for the current year to hospitals eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. No payments under the Medicaid upper payment limit are being made to State government-owned or operated facilities. Up to the difference between Medicaid payments and 100 percent of what would have been paid under Medicare payment principles may be paid to privately owned and operated facilities, in accordance with applicable state and federal laws and regulations, including any provision specified in appropriations by the Florida Legislature. Up to the difference between Medicaid payments and 100 percent of what would have been paid under Medicare payment principles may be paid to non-State government-owned or operated facilities in accordance with applicable state and federal laws and regulations, including any provisions specified in appropriations by the Florida Legislature.

VIII. Medicaid Global Fee Reimbursement Methods

A. Methods Used in Establishing Payment Rates

Reimbursement for adult (age 21 and over) heart and liver transplant evaluations and transplant surgery services will be paid the actual billed charges up to a global maximum rate established by the Agency. These payments will be made to physicians and facilities that have met specified guidelines and are established as designated transplant centers as appointed by the Secretary of the Agency. The global maximum reimbursement for transplant surgery services is an all-inclusive payment and encompasses 365 days of transplant related care. Only one provider may bill for the evaluation phase, and only one provider may bill for the transplant phase.